A National Survey of U.S. Internists' Experiences with Ethical Dilemmas and Ethics Consultation

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OBJECTIVE: **To identify the ethical dilemmas that internists encounter, the strategies they use to address them, and the usefulness of ethics consultation.**

DESIGN: **National telephone survey.**

SETTING: **Doctors' offices.**

PARTICIPANTS: **General internists, oncologists, and critical care/pulmonologists (*N* = 344, 64% response rate).**

MEASUREMENTS: **Types of ethical dilemmas recently encountered and likelihood of requesting ethics consultation; satisfaction with resolution of ethical dilemmas with and without ethics consultation.**

RESULTS: **Internists most commonly reported dilemmas regarding end-of-life decision making, patient autonomy, justice, and conflict resolution. General internists, oncologists, and critical care specialists reported participating in an average of 1.4, 1.3, and 4.1 consultations in the preceding 2 years, respectively (P < .0001). Physicians with the least ethics training had the least access to and participated in the fewest ethics consultations; 19% reported consultation was unavailable at their predominant practice site. Dilemmas about end-of-life decisions and patient autonomy were often referred for consultation, while dilemmas about justice, such as lack of insurance or limited resources, were rarely referred. While most physicians thought consultations yielded information that would be useful in dealing with future ethical dilemmas (72%), some hesitated to seek ethics consultation because they believed it was too time consuming (29%), might make the situation worse (15%), or that consultants were unqualified (11%).**

CONCLUSIONS: **While most internists recall recent ethical dilemmas in their practices, those with the least preparation and experience have the least access to ethics consultation. Health care organizations should emphasize ethics educational activities to prepare physicians for handling ethical dilemmas on their own and should improve the accessibility and responsiveness of ethics consultation when needed.**

KEY WORDS: **questionnaires; internal medicine; ethics, clinical; ethicists; referral and consultation.**
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Ethical problems routinely arise in the hospital and outpatient practice setting,[1,2] and ethics consultation services have become commonplace in health care institutions to assist staff and patients in resolving ethical dilemmas or disputes.[3–5] Indeed, hospitals in the United States are mandated to maintain some mechanism to resolve ethics issues,[6] and the scholarly literature has largely encouraged development of these resources. Furthermore, criteria for educating and training consultants and for standardizing the process of consultations have been published.[7]

Despite this endorsement of ethics consultation, little empiric evidence exists about the use of ethics consultation or its perceived effectiveness. Studies evaluating consultation services indicate to date that persons who request consultation are reasonably satisfied,[8–13] and 3 controlled studies in the intensive care setting suggest that automatic ethics consults for patients at great risk of dying provide some benefit to patients and clinicians, and may optimize resource use.[14,15,16] There has been little systematic study of the kinds of ethical dilemmas internists confront, the kinds of dilemmas referred for consultation, the effectiveness of ethics consultation, barriers to the use of ethics consultation, and physicians' satisfaction with the resolution of ethical dilemmas. Accordingly, a national survey of U.S. internists was conducted to address these questions.

METHODS

Study Population

A national sample of internists was randomly selected from the American Medical Association Master List of Physicians and Medical Students for Mailing Purposes, a list of all medical students and licensed physicians in the United States. Two hundred physicians were selected from each of 3 internal medicine specialty or subspecialty groups: general internal medicine, hematology/oncology, and critical care/pulmonary medicine. This selection strategy was chosen to capture both physicians who serve patients with illnesses that require life and death decisions, and physicians serving patients whose care is generally provided in the outpatient setting and requires more routine decisions. Physicians were ineligible for this study if they reported being in practice for less than a year or if they spent less than 20% of their time in direct patient care. Respondents were not paid to participate. Among the 600 physicians randomly selected, 62 were ineligible and 1 was deceased. Among the 537 eligible physicians, 344 physicians completed an interview (64% response), 76 (14%) actively refused, and 117 (22%) could not be located. Respondents who were self-employed in solo practice were

significantly less responsive (49%) than respondents in all other types of practice settings (65%; $P < .05$).

Survey Development

A survey instrument was drafted based on a review of the ethics consultation literature. The term "ethical dilemma" has a very specific meaning for philosophers as a situation requiring a choice between what seems to be equally desirable or undesirable alternatives, each of which seems to be justified by a moral rule or principle.[17] In designing our questionnaire, however, we did not assume that clinicians have the time, analytic skills, or inclination to make such a reasoned assessment of the relative merits of the competing concerns and can confidently say that the alternatives they face are equally desirable on moral grounds. We assumed that physicians face situations in which they are torn between competing concerns that would lead them to act in opposing ways and under these circumstances, they sense that they face ethical dilemmas. We intentionally did not define ethical dilemmas and problems because we wanted to elicit examples of ethical problems as physicians define and perceive them. In order to be certain that the questionnaire could reliably accomplish this task, questionnaire development involved cognitive interviewing with a small group of general internists, oncologists, and critical care specialists, followed by field pretesting of a completely revised instrument with another group of board-certified internists.[18,19]

The cognitive method consisted of debriefing respondents after completion of each section of the questionnaire. A series of questions about questionnaire items was constructed and asked for cognitive responses from each respondent to ensure that all respondents understood questions in the same way. For example, respondents were asked what they included under the rubric "ethical dilemma." Verbatim responses were recorded and each respondent's list of items was evaluated to ensure that the cognitive domain was similar for all respondents. Respondents were also asked directly about any inconsistencies noted in responses across questions in order to determine whether inconsistencies were caused by poorly formed questions. Respondents were also asked how they came to choose their responses to the rating questions, and what specifically led to higher and lower ratings.

After cognitive testing, the questionnaire was pretested. To further refine phrasing and formatting of questions, the pretest was behavior coded. This involved audiotaping of the pretest interviews followed by the replaying of the interview, focusing on a selected set of common reading and response behaviors. Questions that were still in the questionnaire, but which were difficult for interviewers to read or respondents to answer, were revised and retested to create a thoroughly tested questionnaire with uniformly understood questions. In the final questionnaire, the item requesting respondents to report a recent ethical dilemma was worded as follows:

> Now I would like to ask you about the practice site where you see the largest number of patients. I refer to this as your primary practice site in the following questions. Can you think of a recent ethical dilemma you experienced at your primary practice site? The example can come from any aspect of patient care or institutional interaction, and it would be best if you picked a situation that has completely run its course.

The questionnaire contained questions related to 5 domains: 1) description of the most difficult ethical dilemma encountered, the most recent ethical dilemma encountered, and the most recent ethical dilemma, if any, referred for ethics consultation; 2) the strategies employed by physicians to address ethical dilemmas; 3) experiences with ethics consultation including the need for, use of, and satisfaction with ethics consultation services; 4) sociodemographic, training, and practice characteristics of physicians; and 5) training and experience with medical ethics. The last domain queried respondents about whether they had attended 6 or more bioethics rounds, a bioethics conference, or an intensive bioethics course, whether they were confident about knowledge of current standards of ethics; and whether they had previously or currently served on a clinical ethics committee.

To measure respondent satisfaction with resolution of ethical dilemmas, we used an 11-point scale (with 0 being "not satisfied at all" and 10 being "extremely satisfied"). To measure physician assessment of the usefulness of ethics consultation in reaching better ethical decisions a similar 11-point scale was used. The survey instrument is available upon request.

Survey Administration

Computer-assisted telephone interviews (CATI), lasting an average of 26 minutes, were conducted between October 1999 and March 2000 by trained interviewers from the Center for Survey Research at the University of Massachusetts, Boston.

Human Subjects Protection

Participation did not involve the collection of personally identifiable information. The Office of Human Subjects Research at the Clinical Center of the National Institutes of Health approved the study and exempted it from review by an Institutional Review Board.

ANALYSIS

Open-ended responses were coded as follows: investigators reviewed a 20% random sample of responses to identify major themes and to establish a coding scheme. The coding scheme for ethical dilemmas encompassed broad categories such as "end of life care" and "justice" (see Appendix for the full coding scheme). Dilemmas regarding "patient autonomy" typically involved questions regarding advance directives, patients who could not make decisions

for themselves, or whose decision-making capacity was questionable, as well as other dilemmas noted in the Appendix. The "end-of-life" code was assigned to dilemmas involving questions about appropriate care for terminally ill patients. The "conflict" code was assigned for disagreements among any combination of patient, family, or the health care team. Dilemmas about "justice" were considered to involve questions about fairness in the delivery of medical care, particularly questions about lack of access or insurance for medical care, unfair denial of claims, and questions of allocation or distribution of limited resources. A response could be assigned up to 3 codes if applicable. Two investigators assigned codes to each response and 3 investigators discussed coding disagreements until consensus was reached.

We developed a 6-point index that was a combination of physician training and physician experience with medical ethics. This training/experience index was comprised of 1 point for each of the following: attendance at 6 or more bioethics rounds, participation in a bioethics conference or intensive bioethics course, and a report of general confidence about knowledge of current standards of ethics; and 2 points for past or current participation on a clinical ethics committee. Possible scores ranged from 0 for no experience to 5 points for the most experience. For some analyses, we used the index as a continuous variable, and for other analyses, we divided the index into categories of low (0 to 1 points), medium (2 to 3 points), or high (4 to 5 points).

Descriptive statistics were used to summarize response frequencies. To compare subspecialties, we used χ^2 tests for categorical variables, and 1-way analysis of variance for continuous variables.

Multivariable logistic regression analysis to determine factors associated with availability of ethics consultation at the respondents' predominant practice site included type of practice (group, solo, other); hospital size, whether the hospital is public or private; population of the practice community; and percentage of managed care reimbursement. Multiple logistic regression analysis to determine factors associated with the likelihood of respondents requesting a consultation included score on the training/experience index (high vs low) and subspecialty.

Multiple linear regression was performed to determine physician satisfaction regarding their own efforts to resolve dilemmas and with ethics consultation.

RESULTS

Study Participants

Of the 344 participating physicians, 95 were general internists (53% response rate), 130 were hematologist/oncologists (72% response rate), and 119 were pulmonary/critical care physicians (67% response rate). The sociodemographic and practice characteristics of the 3 groups were similar except that general internists had a significantly lower percent ($P < .01$) of medical school faculty appointments than oncologists and critical care/pulmonologists (Table 1).

Physicians had varied exposure to the field of bioethics, with 53% reporting attendance at 6 or more bioethics rounds; 35% reporting attendance at a bioethics conference; and 21% reported serving on an ethics committee.

Experiences with Ethical Problems

Ninety-five percent of physicians reported a dilemma they found most difficult to resolve and 89% of physicians recalled a specific recent ethical dilemma. Recent dilemmas occurred an average of 6.5 months prior to the interview (median = 3 months). The distribution of the types of dilemmas that were the most difficult and the most recent were not statistically different. We report an analysis of the latter because the most recent dilemma was more likely to be accurately recalled. Physicians reported that the most recent ethical dilemmas they confronted were end-of-life issues, patient autonomy issues, justice issues, and conflicts among parties (Table 2). Thirty-seven percent of dilemmas related to more than one type of ethical issue.

The most recent ethical dilemmas described by physicians differed by subspecialty. General internists described more issues relating to justice, such as insurance coverage ($P < .01$), while oncologists were more likely than the other subspecialists to describe dilemmas regarding truth telling, such as the revelation of a terminal cancer diagnosis ($P < .05$). Critical care specialists were more likely than the other subspecialists to describe dilemmas involving end-of-life issues and situations when patient decision-making capacity was questionable ($P < .01$) (Table 2).

Strategies for Dealing with the Most Recent Ethical Dilemma

The most helpful person physicians spoke to when resolving the most recent dilemma they encountered was another physician or colleague (42%). A small number (14%) of physicians reported that they spoke with no one or that no one they spoke to was helpful. Obtaining validation from another person for an existing approach to a problem was the benefit cited most often. Other benefits included receiving a fresh perspective or new information, or having the person take some action, provide mediation, or make specific recommendations. While the most helpful person to consult was a physician colleague, the most helpful thing that physicians did themselves to resolve issues was to meet with the patient or family.

Physician satisfaction with the decision made to resolve the most recent dilemma was 7.0 ± 3.0 (median 8) out of 10. When asked what would need to change for them to be more satisfied, the top 4 responses were improving the decision-making process to make it more efficient, inclusive, cooperative, or communicative (26%); changing the knowledge, attitudes, or understanding of a clinician, patient, or family member (19%); changing social or institutional policy, regulations, laws, insurance, or the cultural

Table 1. Physician Personal and Professional Characteristics, %

	All Respondents (*N* = 344)	General Internists (*N* = 95)	Hematologists-Oncologists (*N* = 130)	Critical Care/Pulmonologists (*N* = 119)
Gender				
Male	80	77	78	84
Female	20	23	22	16
Race/ethnicity[†]				
White	77	76	77	76
Nonwhite	23	24	23	24
Medical training outside U.S.				
None	70	73	70	67
All or some	30	27	30	33
Ethics training and experience				
Low	36	50	35	25
Medium	48	43	48	51
High	17	7	17	24
Population of practice community[‡]				
≤100,000	21	25	18	21
100–500,000	32	37	33	28
>500,000	47	37	49	51
Practice type[§]				
Solo	11	13	15	6
Group	62	61	62	62
Other	27	27	22	32
Medical school faculty appointment	43	26	49	49
Managed care reimbursement				
≤30%	54	52	57	53
>30%	46	48	43	47
Characteristics of major practicing hospital				
Public	41	36	45	40
Private	59	64	55	60
For-profit	17	21	11	21
Nonprofit	83	79	89	79
≤300 beds	42	46	44	36
300–750 beds	44	41	42	47
>750 beds	15	13	14	17

* *Percents are calculated for total responding in each category.*
[†] *Race/ethnicity was self-reported and coded according to Bureau of the Census categories.*
[‡] *Population within a 20-mile radius of practice.*
[§] *Other practice types included: academic, VA, military, hospital based, and training programs.*

environment (19%); and changing clinical management or outcome (14%).

Availability of Ethics Consultation

While the vast majority of physicians (79%) reported that ethics consultation services were available at their predominant practice site, 19% reported that such services were unavailable, and 2% did not know. Examined by specialty, 75% of general internists, 75% of oncologists, and 92% of critical care specialists reported that they had a process for requesting an ethics consultation at their predominant practice site ($P = .001$ for critical care compared to other groups). Physicians whose practices were hospital based or affiliated with large organizations were significantly more likely to have access to ethics consultation services at their predominant practice site than physicians who were in either group practices (odds ratio [OR], 4.3; 95% confidence interval [CI], 1.6 to 11.3) or solo practices (OR, 12.4; 95% CI, 1.4 to 37.9). Also, physicians practicing in communities with population of over 500,000 were significantly more likely to have access to ethics consultation services than those practicing in communities under 100,000 (OR, 2.33; 95% CI, 1.14 to 4.78).

Use and Evaluation of Ethics Consultation

Overall, 82% of respondents had some prior experience with ethics consultation. Nearly two-thirds of physicians (65%) reported ever having personally requested an ethics consultation, and 52% reported ever being involved in an ethics consult initiated by someone else. During the 2 years prior to the survey, general internists, oncologists, and critical care/pulmonary specialists reported participating in an average of 1.43, 1.26, and 4.13 consultations, respectively ($P < .0001$).

Table 2. Physicians' Ethical Dilemmas

	Most Recent Ethical Dilemmas			Ethical Dilemmas Leading to Ethics Consultation		
	General Internists	Hematologist-Oncologists	Critical Care/ Pulmonologists	General Internists	Hematologist-Oncologists	Critical Care/ Pulmonologists
N	82	119	113	48	65	95
End of life, %*	51†	55	78	69	71	79
Patient autonomy, %	35†	36	61	54	51	63
Justice, %	23†	13	6	0	0	2
Conflicts between parties, %	35	34	38	38	43	38
Professional conduct, %	11	8	4	6	5	2
Truth telling, %	6‡	12	4	0	5	3
Religious or cultural issues, %	6	4	4	10	5	3
Other, %	10	12	6	8	7	7

** The percentage of responses that were assigned to each code from the scheme outlined in the Appendix. Results add up to more than 100% because up to 3 codes were assigned to each response. Responses of "don't know," "no," and uninterpretable responses were omitted.*

† *Percentages differ among subspecialties;* P < *.01.*

‡ *Percentages differ among specialties;* P < *.05.*

§ *Other dilemmas involved abortion, genetic testing, substance abuse, research participation, and beneficence.*

A multiple logistic regression model revealed that those physicians who were more knowledgeable and experienced in ethics were significantly more likely to request an ethics consultation (OR, 4.75; 95% CI, 1.76 to 12.85). Several individual items in the index were also highly correlated with the likelihood of requesting an ethics consult: attending 6 or more bioethics rounds ($P < .001$), feeling confident about one's knowledge of current standards in ethics ($P < .001$), and being a member of an ethics committee ($P < .001$). In addition, critical care physicians were significantly more likely than physicians practicing general internal medicine (OR, 9.25; 95% CI, 3.97 to 21.74), or oncology (OR, 7.22; 95% CI, 3.24 to 16.13) to request ethics consultations. Physicians who were more trained and experienced in ethics were located in practices where consultation was more available than were physicians where consultation was unavailable (mean scores on the ethics training/experience index, 2.3 vs 1.8; $P < .01$).

In general, those ethical issues that prompted an ethics consultation were similar to the ethical issues identified in the most recent dilemma, with some notable exceptions (Table 2). Nearly a quarter of the dilemmas recently encountered by internists and an eighth of those encountered by oncologists were related to issues of justice, yet none of the dilemmas referred for ethics consultation concerned issues of justice. Conversely, ethical issues related to end-of-life care and patient autonomy were overrepresented among the ethical questions brought to an ethics consultant for assistance.

Forty-one percent of physicians expressed some hesitation about using ethics consultation. The major reservations were that ethics consultation requires too much time, that consultation makes the situation worse, and that consultants are unqualified (Table 3).

The most commonly reported needs for assistance in recent ethical situations that led to ethics consultation requests were mediation of a conflict, skill and experience with ethical issues, and decisions or advice (Table 3).

Twenty-six percent of physicians who had either personally initiated a consultation request or participated in one initiated by others reported that the consultation changed the existing plan of treatment, while 72% reported that they learned something from the consultation that might prove helpful in the future. Overall, 86% reported that they were very or somewhat likely to call another ethics consult.

Among respondents who had requested an ethics consult, the mean satisfaction score was 7.4 ± 2.4 (median = 8.0) on the scale of 0 to 10. In a linear regression model, physicians with a graduate degree in addition to their medical degree were significantly less satisfied (score = 6.8) than those without an additional degree (mean score = 7.8) ($P = .02$). Physicians affiliated with a hospital having more than 750 beds were more satisfied with consultation (mean score = 8.2) than physicians affiliated with hospitals having 300 or fewer beds (mean score = 6.7) ($P < .01$).

DISCUSSION

This is the first national survey examining the nature of the ethical issues physicians confront and their utilization of ethics consultation services. Four findings are noteworthy.

First, nearly 90% of physicians in this study encountered ethical dilemmas recently. However, physicians have a wide range of skills and available resources with which to address them. Most importantly, physicians with the least training and experience are the least likely to have access to and request ethics consultative advice. In light

Table 3. Internists' Reactions to Ethics Consultation

Reasons for Hesitation in Using Ethics Consultation, %		Types of Ethics Assistance Needed, %	
Process is too time consuming	29	Help in mediating conflict among different points of view	77
Consultations make things worse	15	Someone with special skills and experience in ethics	75
Consultants are unqualified	11	Someone capable of providing clear direction	74
Consultations are unhelpful	9	Someone who knows the law, institutional policy, federal regulations, or national standards	70
Solutions are not consistent with good practice	9	Clarification of ethical issues	67
Difficult to access	3	Alternative suggestions for ethically appropriate courses of action	63
Confidentiality concerns	3	Professional reassurance that a decision was the correct one	57
Fear of reprisal	1	More complete information	39
Other response	22		

of the frequency with which physicians encounter ethical dilemmas and handle them on their own, it is important that health care organizations focus considerable effort on teaching ethics and training clinicians to resolve ethical dilemmas. While much has been written about ethics curricula in medical training,[20–26] the results of this study highlight the need to provide and evaluate ethics education in medical school, residency, or subsequently in continuing education programs.

Second, physicians encounter different types of ethical dilemmas to varying extents depending upon their subspecialty. While end-of-life care issues are most common, nearly a quarter of dilemmas encountered by general internists and an eighth of those encountered by oncologists entail questions of justice. It may be that general internists, who are more often primary care providers and gatekeepers, are more likely to face ethical dilemmas related to lack of insurance for their patients and limited reimbursement for their services. Another noteworthy finding is that critical care/pulmonary specialists encounter more ethical dilemmas around end-of-life care than oncologists do. It may be that patients who have lived with a diagnosis of cancer are more adjusted to mortality and death, while the acute course of patients admitted to the intensive care unit frequently leads to a more tumultuous dying process generating more questions and conflicts about the ethically appropriate approach to care. Aside from encountering differing types of ethical questions, the extent to which physicians refer these dilemmas for ethics consultation varies depending upon the type of ethical dilemma.

Third, a significant minority of physicians report a lack of access to ethics consultation services. Despite the Joint Commission on Accreditation of Healthcare Organizations requirement that all health care organizations provide a mechanism for resolving ethical problems, 19% of physicians in this study reported that, to their knowledge, ethics consultation services are not available to them.

Finally, in evaluating ethics consultation, most internists report positive experiences and consider ethics consultation useful, productive of satisfactory solutions, and instructive for the future. However, a significant minority of physicians (41%) expresses reservations, about either ethics consultation generally, or the quality of the service offered at their particular institution.

In considering how ethics consultants should interact with clinicians, several authors have argued that the role of the ethicist is not to dictate the "right" solution, but to help create the environment and time in which ethical deliberation and mediation can take place.[7,27–29] A consultative atmosphere that fosters fair, open, and unhurried discussion is likely to be time consuming.[30] This recommendation is in tension with the views of the physicians in this study. Instead, these data suggest that ethics consultation could be made more responsive to physicians by 1) making the process more expeditious; 2) offering more specific recommendations in addition to theoretical analysis; 3) ensuring that ethicists have strong ethics training and clinical experience; and 4) better informing institutional members about available services. The challenge for ethicists is to make consultation more efficient to accommodate the need for an expeditious resolution, while providing a forum for thoughtful and inclusive deliberation.

This study has several limitations. Although the findings of this study are generalizable to the medical specialties surveyed and our sample reflects their demographic composition,[31] they may not apply to other specialist groups. Second, data were collected through physician self-reports. There was no validation of the reports, which may have differed from actual behavior. In particular, the frequency with which physicians reported requesting and participating in ethics consultations was not verified and may be high. In a national survey of U.S. hospitals conducted by the Department of Veterans and reported by Ellen Fox to the American Society of Bioethics and Humanities in 2002, the median number of consultations performed annually by ethics consultation services was 3 (range 0 to 300). Third, while the response rate in the study is similar or better than that reported for other physicians surveys,[32,33] we cannot exclude the possibility of response bias. Responders were more likely to be working in larger practices than nonresponders and may be more familiar with ethics consultation services, which have become prevalent in large health care organizations.

Finally, the exploratory nature of the analysis warrants conservative interpretation of its significance.

In summary, ethical dilemmas commonly arise in the course of today's internal medical practice, and while the availability of ethics consultation has become the norm, it is not available for a fifth of practitioners at their predominant practice site. Furthermore, some kinds of ethical issues are brought to ethicists' attention more often than others. Clinicians who might find ethicists' opinions most useful are the least likely to avail themselves of this resource. Perhaps attention to this pattern of encounter with ethical issues and use of consultation might serve as a stimulus for improving the contribution of ethics consultants in today's ethically charged practice environment.

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Appendix A

Ethical Issues

- Patient autonomy
  - Advance directives/durable power of attorney
  - Patient's autonomy is threatened
  - Making a decision for a competent patient
  - Competency of patient is questionable
  - Surrogate decision making
    - Conflict between doctor and surrogate
    - Conflict between surrogates
    - Competency or validity of surrogacy is questionable
  - Patients without someone to make decisions for them
  - Refusing a recommended treatment
  - Demanding treatment
  - Pediatric assent
  - Noncompliance
  - Informed consent
- Truth telling, confidentiality, privacy, and communication difficulties
  - Withholding or disclosing information, diagnosis, or prognosis from patient, family, or others
  - Communication difficulties
- End-of-life issues
  - Withholding therapy
  - Do-not-resuscitate orders
  - Euthanasia
  - Deciding how aggressively to treat when chances of survival are limited
  - Pain and palliative care
- Conflict
  - Disagreement between parties involved
  - Disputes during decision making
  - Refusing a recommended treatment
- Religious/cultural/race/language/socioeconomic class issues
- Justice issues/insurance coverage/resource allocation
  - Indigent care/uninsured
  - Managed care
  - HMOs
  - Limited drug formulary
  - Financial incentives
  - Limited resources
  - Individual versus others' needs
- Professional conduct or misconduct
  - Obligation to treat
  - Conflict of interest
  - Financial motivation
  - Medical errors
  - Research conduct or misconduct
  - Honesty/dishonesty
- Other (organ donation, genetic issues, abortion, quality of life)